



Roger A. Sevigny
Commissioner

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Alexander K. Feldvebel
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BULLETIN
Docket No.: INS No. 08-024-AB

TO: All New Hampshire Licensed Health Insurance Companies, Health Maintenance Organizations, Fraternal Benefit Societies and Third Party Administrators

FROM: Roger A. Sevigny
Insurance Commissioner

DATE: May 6, 2008

A handwritten signature in black ink, appearing to read "RAS", is placed over the "FROM:" line.

RE: Standards for Form and Rate Review and Approval of Limited Benefit Policies

This Bulletin clarifies the standards that the department will apply in reviewing limited benefit policies.

Limited benefit policies under 1901.06(l) are those group supplemental and individual policies that contain a medical benefit component, but do not meet the minimum standards set forth in Ins. 1901(b)-(k).

A group supplemental policy or an individual policy may be approved as a limited benefit policy under Ins. 1901.06 (l) if the policy meets the following standards:

- 1) The policy is a group supplemental or individual policy. No limited benefit policy may be marketed and sold by an insurer as a group policy. In determining whether a policy provides group supplemental coverage, the department will apply the standards set forth in the attached Field Assistance Bulletin No. 2007-04. These standards are as follows:
 - a. The supplemental coverage must be provided under a separate policy or certificate of insurance and must be issued by an entity other than the entity that provides the primary coverage under the plan. The filing should identify the primary plan or the primary type of coverage for which supplemental coverage is provided.
 - b. The supplemental coverage must be specifically designed to fill gaps in primary coverage such as coinsurance or deductibles.
 - c. The supplemental coverage cannot be secondary or supplemental under a coordination of benefits provision.
 - d. The value of the supplemental coverage generally should not exceed 15 percent of the value of the primary coverage. A carrier may request that the department waive the requirement that the value of the supplemental coverage not exceed 15 percent of the value of the primary coverage. The Department shall grant the waiver if it determines that a waiver is in the public interest; the policy meets the others standards set forth in

the guidance; and the department determines that the benefits are reasonable in relation to the premium rate for the policy.

e. The supplemental health insurance product must comply with the applicable rating rules.

(2) The policy provides benefits that do not meet the minimum standards set forth in Ins 1901.06 (b), (c), (d), (e), (f), (g), (i), (k).

(3) The policy is not a specified disease policy under Ins. 1901.06(h) or a disability income policy as described in Ins 1901.06(j).

(4) The policy has been submitted for rate review and form review and has received approval. In regard to rate review, the carrier must establish to the actuary's satisfaction that the benefits provided are reasonable in relation to the premium rate for the policy.

(5) The policy does not contain any provision that is unjust, unfair, inequitable, misleading, deceptive, or that allows misrepresentation of the terms, conditions, or benefits provided by the policy.

(6) The policy contains the Outline of Coverage required by Ins 1901.07(l).

(7) The policy contains the Notice to Buyer required in Ins 1901.07(a) (18).

(8) The Outline of Coverage meets the requirements set forth in Ins 1901.07(b) as well as Ins 1901.07(l).

(9) The application for the policy contains the disclosure set forth in Ins 1901.07(a)

A policy that is sold as a group supplemental or an individual policy and that contains benefits for medical coverage that do not fall within the policy categories set forth in Ins. 1901 (basic hospital expense coverage; basic medical-surgical expense coverage; basic hospital/medical-surgical expense coverage; hospital confinement indemnity coverage; major medical expense coverage; basic medical expense coverage; disability income protection coverage; accident only coverage; and specified disease coverage) may be approved as a limited benefit policy if the policy meets the standards set forth in this guidance. Travel policies are an example of this type of policy. Travel policies may provide limited benefits for medical expenses, where the underlying primary major medical policy would not provide benefits.

Approval of limited benefit policies will be limited to policies that provide supplemental excepted benefits under HIPAA. Limited benefit policies that purport to provide benefits that are not excepted supplemental benefits, limited excepted benefits, non-coordinated excepted benefits or excepted benefits as those terms are defined by HIPAA will not be approved.



U.S. Department of Labor

Field Assistance Bulletin No. 2007-04

December 7, 2007

Memorandum Virginia C. Smith, Director of Enforcement
For: Regional Directors

From: Daniel J. Maguire
 Director of Health Plan Standards and Compliance Assistance

Subject: Supplemental health insurance coverage as excepted benefits under HIPAA and
 related legislation

Issue

What are the circumstances under which supplemental health insurance coverage satisfies the requirements for excepted benefits under sections 732(c)(3) and 733(c)(4) of ERISA?

Background

HIPAA Health Reform and Related Legislation

Titles I and IV of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (HIPAA) amended the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (Code), and the Public Health Service Act (PHS Act) to improve portability, access, and continuity with respect to group health plan coverage provided in connection with employment. These laws include limitations on preexisting condition exclusions, require issuance of certificates of creditable coverage, provide special enrollment rights, and prohibit discrimination on the basis of any health factor. Later amendments to these laws provide protections relating to mental health parity, hospital lengths of stay following childbirth, and post-mastectomy coverage. Regulations issued by the Departments of Labor, the Treasury, and Health and Human Services (the Departments) on these group market provisions are contained in 29 CFR Part 2590, 26 CFR Part 54, and 45 CFR Parts 144 and 146. Additional reforms were provided in the PHS Act for health coverage in the individual market and are contained in 45 CFR Parts 144 and 148.

In general, these health reform provisions apply to group health plans (generally plans established or maintained by employers or employee organizations, or both) and health insurance issuers in the group or individual market. However, these provisions do not apply to certain excepted benefits. In general, if all benefits under a plan or coverage are excepted benefits, then the plan and any health insurance coverage under the plan does not have to comply with the health reform requirements, and the coverage may not qualify as creditable coverage.

Supplemental Health Insurance Coverage

One category of excepted benefits is supplemental excepted benefits. Benefits are supplemental excepted benefits only if they are provided under a separate policy, certificate, or contract of insurance and are either Medicare supplemental health insurance, TRICARE supplemental programs, or similar supplemental coverage provided to coverage under a group health plan. The phrase “similar supplemental coverage provided to coverage under a group health plan” is not defined in the statute or regulations. However, the regulations clarify that one requirement to be similar supplemental coverage is that the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (but similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision). 29 CFR 2590.732 (c)(5)(i)(C), 26 CFR 54.9831-1(c)(5)(i)(C), and 45 CFR 146.145(c)(5)(i)(C).

Coordination of Administration

Various situations have come to the attention of the Departments that raise concerns about whether all of the coverage that is being marketed as similar supplemental coverage actually qualifies as such.

Section 104 of HIPAA requires the Secretaries of Labor, the Treasury, and Health and Human Services to ensure that guidance under HIPAA issued by the Departments that relates to the same matter be administered so as to have the same effect at all times. In accordance with section 104 of HIPAA, each of the Departments is issuing guidance concerning the requirements for “similar supplemental coverage” that qualifies as benefits excepted from the requirements of HIPAA. The guidance being issued has been developed on a coordinated basis by the Departments. HHS is also issuing guidance on similar supplemental coverage for the individual market.

Discussion

In order to prevent issuers from avoiding compliance with ERISA’s health reform provisions by issuing multiple insurance contracts in connection with a plan, this bulletin establishes an enforcement safe harbor under which supplemental health insurance will be considered excepted benefits for purposes of Part 7 of ERISA. Similar supplemental coverage that does not meet the standards for this safe harbor may be subject to enforcement actions by the Department.

To fall within the safe harbor, a policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan and must be specifically designed to fill gaps in primary coverage.

In addition, the Department believes that the value of the supplemental coverage must be significantly less than the value of the primary coverage that it supplements. To fall within the enforcement safe harbor, the cost of supplemental coverage may not exceed 15 percent of the cost of the plan’s primary coverage. The Department will determine cost in the same manner as the “applicable premium” is calculated under a COBRA continuation provision.⁽¹⁾ Some plans subject to HIPAA titles I or IV are not subject to the COBRA continuation coverage requirements, such as

plans maintained by an employer with 20 or fewer employees. For these plans, the Department will compute cost as if they were subject to COBRA. (For insured coverage – all supplemental coverage and primary coverage to the extent insured – the COBRA cost is, for purposes of this bulletin, the cost of the insurance coverage.)

Issuers of Medicare supplemental health insurance (commonly referred to as “Medigap”) generally are subject to prohibitions against discrimination based on enrollees’ or potential enrollees’ health status. Accordingly, to fall within the enforcement safe harbor, the coverage may not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual.

Conclusion

For purposes of enforcing ERISA’s health reform provisions, the Department will treat coverage as “similar supplemental coverage provided to coverage under a group health plan” under 29 CFR 2590.732(c)(5)(i)(C), within the enforcement safe harbor, if it is a separate policy, certificate, or contract of insurance and if it satisfies all of the following requirements:

1. **Independent of Primary Coverage.** The supplemental policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or part of the same group of trades or businesses under common control, within the meaning of section 52(a) or (b) of the Code, are considered a single entity.
2. **Supplemental for Gaps in Primary Coverage.** The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision.
3. **Supplemental in Value of Coverage.** The cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15 percent of the cost of primary coverage. Cost is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.
4. **Similar to Medicare Supplemental Coverage.** The supplemental policy, certificate, or contract of insurance that is group health insurance coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

Questions concerning the information contained in this Bulletin may be directed to the Office of Health Plan Standards and Compliance Assistance at 202.693.8335.

Footnotes

1. Under the COBRA rules, plans are generally permitted to charge up to 102 percent of the applicable premium. Thus, COBRA cost for purposes of this bulletin is 100 percent of the applicable premium, not 102 percent of the applicable premium that the plan is generally permitted to charge under the COBRA rules.

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